Employment Status, Family Income, Contraceptive Availability, and their Effects on the Use of Long Term Contraceptives in Sukoharjo, Central Java

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ABSTRACT

Background: Rapid population growthcause population burden on earth and imbalance population distribution. This situation in turn make cause public health and social problems. One of the methods that can be used to control population growth is long term contraceptive use. The Indonesian Demographic and Health Survey (SDKI) showed that employed mothers were more likely to use long term contraceptive than unemployed mothers. Contraceptives are available for free at Family Planning Clinic (KKB). This study aimed to analyze the effect of employment status, family income, and contraceptive availability, on the use of long term contraceptive among women and men of reproductive age in Sukoharjo, Central Java.
Subjectsand Method: This was a qualitativeanalytic and descriptive study with phenomenology approach. This study was conducted in Weru, Kartasura, Polokarto, and Tawangsari subdistricts, Sukoharjo, Central Java. The key informants included acceptors of implant, IntraUterine Device (IUD), Female Surgical Method(MOW), and Male Surgical Method(MOP). The data were collected by in-depth interview, Focus Group Discussion (FGD), observation, document review. The data were alayze by interactive analysis. The data were verified by triangulation of data sources.
Results: Two informants reported they chose IUD because they had to work outside the house, undesirable side effects of using oral contraceptive, injection contraceptive, and contraceptive use by their mothers and grandmothers. Some other informants have used implant because of undesirable side effect of using injection contraceptive, such as irregular menstruation and increased body weight. Two other informants have used female surgical method (MOW) because they already have three children and do not want to be pregnant again. Onemale informant reported that hehas used male surgical method (MOP) because already has four children, and he followed the methods his father has used. Most of the long term contaceptive users work outside the house and their incomes were lower than the minimum regional standard wage. Most of the long term contraceptive users receive free contraceptive and additional reward (e.g. free rice). The remaining long term contraceptive users buy contraceptives at the health center and hospital. The contraceptives were supplied by the National Coordinating Board of Population and Family Planning(Badan Kependudukan dan Keluarga Berencana Nasional, BKKBN) at province level. Village midwives did not receive free contraceptive because their practices have not been classified as Family Planning Clinics(KKB).
Conclusion: Availability of contraceptive is a necessary condition for long term contraceptive use. Working outside the house is an additional factor for most women to realize long term contraceptive use.

Keywords: Employment status, family income, availability, long term contraceptive

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BACKGROUND

National Population Growth Rate (LPP) has not experienced much change. LPP in Indonesia in the period 2000-2010 and 2010-2014 amounted to 1.49%. Meanwhile, LPP in Central Java increased from 0.37% to 0.82% in the same period (BPS, 2015; BKKBN, 2014). Furthermore, LPP in Sukoharjo Regency, in 2010-2014 increased by about 0.69% (DKK Sukoharjo, 2014).

Fast LPP can cause an imbalance in the distribution of population in various parts of Indonesia. One of them is the movement of people from villages to cities in search of work. This situation raises a variety of problems such as decreasing the quality of the environment, slums, reducing employment and increasing socio-economic problems. Rapid LPP must be balanced by increasing the fulfillment of quality living needs and in large quantities (Ministry of Health, 2013).

An effective effort to control population growth is through the implementation of the Family Planning (KB) program. The purpose of family planning is to realize the Small, Happy and Prosperous Family Norms (NKKBS) so that they can contribute to changes in the number, composition structure and distribution of population in accordance with the carrying capacity and capacity of the environment (BKKBN, 2015).

The family planning program is an integrated, comprehensive and sustainable program of promotive and preventive activities. Promotive and preventive services include non-MKJP contraceptive counseling and use and the Long Term Contraception Method (MKJP) (Ministry of Health, 2013). So that MKJP is a contraceptive method that must be encouraged (Ministry of Health, 2015). MKJP is a contraceptive method that has relatively long effectiveness between three years to a lifetime consisting of implants, Intra Uterine Device (IUD), Female Operating Methods (MOW) and Male Operating Methods (MOP) (BKKBN, 2014).

The achievement of family planning programs in Indonesia is still far from the 2015-2019 National Medium Term Development Plan (RPJMN) target program. The target of MKJP use is 18.3% in 2014 and is targeted to be 2.5% by 2019. The same target also applies to the prevalence of all types of contraception in women aged 15-49 years from 61.9% to 66.0%. The policy direction and strategy for the use of MKJP is to reduce drop-out by considering the Rational, Effective and Efficient Principles (BKKBN, 2015; IBRA, 2014).

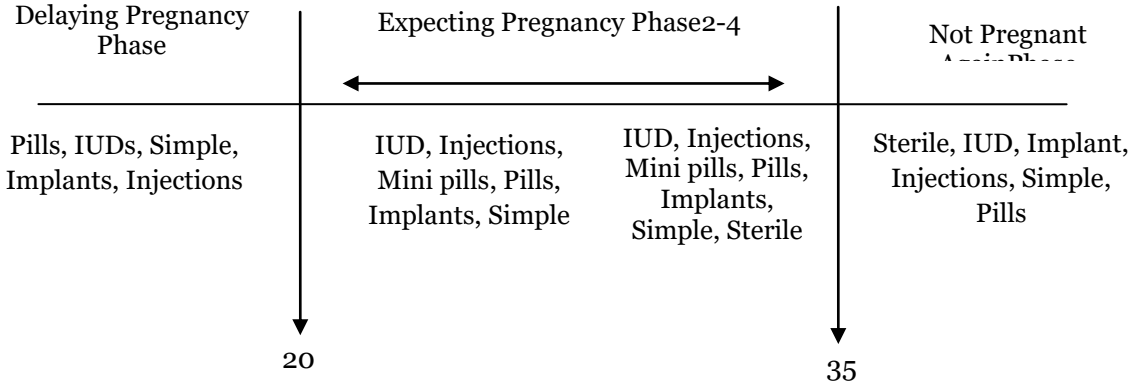

Figure 1.The rational order of contraception

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According to Affandi (2011), the choice of rational contraception is divided into 3 phases, namely (1) the phase of delaying pregnancy: pregnancy and first birth at a minimum age of 20 years which is intended to minimize the risk of mother and child; (2) phase of pregnancy pregnancy: the best distance between first and second children is 2-4 years. If a mother has experienced an alternative miscarriage, family planning can be used to restore health conditions due to curettage and (3) the phase of not pregnant again: a family is expected not to become pregnant again after having 2 children and wife age ≥35 years (Figure 1).

Asih and Oesman (2009) reported factors that had a strong influence on MKJP use, namely age (OR = 3.15), family planning information (TOMA) / religious figure (TOGA) (OR = 1.35), maternal work (OR = 1.35) , the role of print media (OR = 1.35) and knowledge of contraception (OR = 1.34), while Nasution (2011) stated that several factors influence the use of MKJP in Indonesia, namely Fertile Age Women (WUS) over the age of 30 years, number of children more than 1 or 3 children, more than 10 years of age, education level above senior high school and living in urban areas.

The obstacle of using MKJP in East Java is the occurrence of IUD failure, prohibition from the husband and side effects that affect the relationship when having intimate relationships. The purpose of this study was to analyze the work, income and availability of contraceptives that affect the use of MKJP in Sukoharjo Regency.

SUBJECTS AND METHOD

1. Study Design

This was descriptive qualitative with a phenomenological approach. The study was conducted in November 2016-January 2017 in Jatingarang Village, Weru Health Center, Makamhaji Village, Kartasura Health Center, Mranggen Village, Polokarto Health Center and Kedungjambal Village, Tawangsari Health Center.

2. Population and Sampling

The sampling technique in this study was purposive sampling. The informants were chosen who were informative and had experience in accordance with the phenomenon of study with the maximum variation sampling type, namely variations in flexibility or diversity of elements of the community studied and represented by the study. The subjects were 15 active implant family planning participants, IUD, MOW and MOP aged between 15-49 years. Data collection techniques were conducted using in-depth interviews, Focus Group Discussion (FGD), observation and documentation analysis.

3. Data Analysis

Data analysis used was a qualitative interactive analysis model, which was drawing conclusions from the results of interviews conducted by data reduction, data presentation then verification using source triangulation techniques with village midwives, District Office of Women Empowerment and Family Planning (KPPKB), Assistant Family Planning Guidance (PPKB) sub-district and TOMA.

RESULTS

1. Occupation

The increase of women working in several countries reduces the desire to have more children. Women who have their own income can increase the use of contraceptives (BKKBN, 2014). Table 1 shows the livelihoods of residents in Jati-ngarang Village, Weru District. Farmers are the most occupational type (17.48%) in Jatingarang village because most of the area is used for rice fields (120 ha/m^2).

Table 1. The characteristics of the population in livelihoods in Jatingarang Village

Occupation	Gender			
	Male	%	Female	%
- Farmer	505	7.96	303	4.78
- Hodge	837	13.19	272	4.29
- Migrant worker	73	1.15	60	0.95
- Civil servant	51	0.80	39	0.61
- Private doctor	1	0.02	3	0.05
- Private midwife	0	0.00	1	0.02
- Private nurse	0	0.00	1	0.02
- Trained traditional healer	0	0.00	1	0.02
- Entrepreneur	214	3.37	87	1.37
- Private employee	33	0.52	35	0.55
- Government employee	6	0.09	2	0.03
- Others	1,477	23.28	2,344	36.94

Unlike Jatingarang village, Makamhaji village, Kartasura sub-district is close to Solo City. Most of the land is used for population settlement of 177.624 ha/m^2, 23 ha/m^2 for grave land, 7 ha/m^2 of rice fields and 3 ha/m^2 of office space. S, the majority of the population living as private employees is 34.06% (Table 2).

Table 2. The characteristics of the population in the livelihoods of Makamhaji Village residents

Occupation	Gender			
	Male	%	Female	%
- Farmer	5	0.03	0	0.00
- Migrant worker	93	0.53	51	0.29
- Civil servant	331	1.87	220	1.24
- Private doctor	17	0.10	15	0.08
- Private midwife	0	0.00	25	0.18
- Private nurse	15	0.08	35	0.20
- Lawyer and notary public	10	0.06	7	0.04
- Private lecturer	57	0.32	40	0.23
- Entrepreneur	1.613	9.12	1.009	5.70
- Private employee	3.450	19.50	2.575	14.56
- Government employee	205	1.16	117	0.66
- Others	3,007	17.00	4,792	27.09

The work of several family planning participants is a housewife (IRT) so that the family income is obtained from the husband. Even though the family income is from the husband, the decision to do *KB* is handed over to the wife. However, if women work outside the home, the use of MKJP is greater because of the benefits felt in family planning. Statement submitted by IU.J informantsis presented below:

"Kulo namung pedagang mbak (IU. J)"

Translation: I am a seller, miss.

"I work as an employee here. I now use an IUD, just want to find something safe so I don't think like that. My husband just support my decision *(IU. EA)"*

Table 3 shows the livelihoods of the residents of Mranggen Village, Polokarto District. There was 25.43% of the population in Jatingarang Village who have the livelihood of farm laborers/hodge. Most of the village area is used for agricultural land (241.60 ha/m^2).

Table 3.The population characteristics in the livelihood of Mranggen Village

Occupation	Gender			
	Male	%	Female	%
- Farmer	600	6.75	24	0.27
- Hodge	2.000	22.51	259	2.92
- Civil servant	78	0.88	54	0.61
- Private Midwife	0	0.00	2	0.02
- Private nurse	6	0.07	0	0.00
- Lawyer	1	0.01	0	0.00
- Trained traditional healer	0	0.00	3	0.03
- Entrepreneur	66	0.74	9	0.10
- Private entrepreneur	600	6.75	529	5.95
- Private lecturer	3	0.03	3	0.03
- Others	1.108	12.47	3.539	39.84

Table 4. The Characteristics of Population Based on the Employment of Kedungjambal Village

Type of Employment	Gender			
	Male	%	Female	%
- Farmer	252	4.96	259	5.10
- Farm Worker	619	12.18	604	11.89
- Civil Servants	92	1.81	25	0.49
- Private Midwife	0	0.00	1	0.02
- Private Nurse	0	0.00	7	0.14
- Private Lecturer	1	0.02	2	0.04
- Private Employee	126	2.48	189	3.72
- Enterpreneur	389	7.66	410	8.07
- Others	953	18.76	1.152	22.67

Kedungjambal Village, Tawangsari sub-district was similar to Jatingarang and Mranggen Villages. 24.07% of Kedungjambal residents worked as farmers (Table 4). Meanwhile, 22.67% of women worked as housewives.

Working women tend to choose LTCM because they were more aware of the benefits of family planning, they were not required to conduct regular monthly checks to health personnels and reducing the risk of forgetting, thus increasing work productivity. Here is the statement:

"Kalau di kerjaan punya anak 5 kan yo bola bali cuti kan yo piye (IP.W)"

Meaning: If I have 5 children while I am working, I would need more maternity leave, so how about my job?.

2. Income

The effect of income on the use of LTCM was related to purchasing power in contraceptive use. Some policies from the government that ease the acceptors to receive free services of LTCM were by using National Health Insurance (NHI) or simultaneous family planning services conducted at the Community Health Center or Hospital. Expenses charged to acceptors who did not have NHI were still relatively affordable. Installation and release of IUDs and implants in health centers at a cost of Rp. 20,000 according to Regional Regulation No. 12 of 2009 of Sukoharjo District.

The government program on family planning was carried out simultaneously by six times a year in certain months in collaboration with various cross-sectors. Sub-

mission of information on simultaneous family planning services to prospective acceptors was carried out by Assistant Family Planning Guidance (PPKB), village midwives and Village Family Planning Assistants (PPKBD)/Sub PPKBD/Village Clinic Sub (SKD). If the residents did not have a communication tool, the SKD would go around the village or when there was a health center, the information about the implementation of family planning was held simultaneously. Here is the statement regarding the income:

"Pendapatan pedagang niku pinten mbak, paling sehari Rp. 20.000 (IU. J)"

Meaning: my income as a trader for a day is Rp. 20,000.

Table 5. The Characteristics of the Main Informant

Name	Age (years old)	Employment	Income (Rupiah)
IU. SR	33	Housewife	-
IU. L	33	Housewife	-
IU. J	34	Trader	600,000
IU. HR	27	Housewife	-
IU. MY	39	Farmer	1,000,000
IU. SH	33	Housewife	-
IU. HK	31	Housewife	-
IU. SJ	41	Housewife	-
IU. MH	39	Housewife	-
IU. IS	38	Housewife	-
IU. M	49	Labor	1,000,000
IU. W	49	Trader	1,000,000
IU. EA	31	Employee	1,000,000
IU. SS	37	Enterpreneur	500,000
IU. S	46	Enterpreneur	1,000,000

Table 5 showed that the description of the job characteristics of the main informants as LTCM acceptors was dominated by housewife, and the average family income was derived from the husband's income.

3. The Availability of Contraceptive

Contraceptive provider was fully fulfilled by the provincial BKKBN/NCBPFP. The KP-PKB went to the Family Planning Clinic (FPC), there were 36 FPC in Sukoharjo. Every month, the report can be monitored by the results of the acceptor, the amount of contraceptives used before sold out was coordinated to the regency KPPKB with the coordinator in the sub-district to get an additional contraceptive. In Sukoharjo district, the contraceptive supplies has been fulfilled by 100%.

The demand for contraceptive devices and medicines from the Province can be fulfilled. However, there was a contraceptive which was not given by the Province which was one month injection, so that there was only three months injection contraceptive. Here is the statement:"The provision of contraceptive has been fulfilled in each sub-district. PPM was determined by the Provincial BKKBN which was divided equally according to the calculations for each village in the sub-district. *(IP. SS)"*

The family planning program which aimed to ensure the implementation of quality family planning services for family planning participants and reproductive age couples who want family planning but who have not been served, help to supply contraceptive devices, distribute and guarantee the availability of contraception, therefore, the coordination between family planning field officers was needed, sub-district, and

midwives at health centers as health personnels and the implementers of family planning services so that the fulfillment of contraceptive was immediately sent from the district KPPKB to the main health center which was considered as FPC. However, there were some constraints related to networking, the primary health center has networks in the Sub-health Center (Pustu)/Village Health Polyclinic (PKD) and Integrated Service Centers (Posyandu) so that they can do free family planning services but the report remained to the primary health center. The Independent Practical Midwife (IPM)/Private Practice Midwife (PPM) could not be recognized as a FPC, therefore, family planning services were carried out independently/privately because the BPM according to existing policies must be a network of private practice doctors. However, the private practice doctors did not want to be the networks. Here are some statements to support this study:

*"*In PKD, we have to buy the IUD or implants by our own. So our tools were not provided, and therefore, the services were not for free even though it was the network.*(IP. NA)"*

"The availability of contraceptive has been fulfilled, but there was a constraint which was the contraceptive network to the Independent Practical Midwife (IPM) still cannot be implement properly. However, the availability of contraceptive at health center has been fulfilled.*(IP. SS)"*

"Well, the PPM/IPM must be a network with private practice doctors first. But the path to PPM was minimal. We need to get the BPJS contraceptive from a private practice doctor but it was difficult because the doctors rarely want to be the networking. and we should not go directly to the midwife, because there were some rules.(IP. M)"

There were still a number of obstacles in the distribution of contraceptives which need a procedure that could help in taking the contraceptives at the health center pharmacy. Coordination between health personnels in health centers and sub-district PLKBs to alleviate the implementation of family planning programs was needed to increase the coverage of family planning. Here is the statement:

"Actually there was no specific procedure but only policy. If I went to the village, I usually said: "excuse me, I need pil and condom" and they immediately provide the pil and condom. But in here, the needs that I want came from the district and then deliveredto the health center and to the pharmacy, then, I often have problem in taking my needs in pharmacies.The village also complained about this, we have told the doctor but we did not get any solution. Because the network also has the right to receive contraceptives such as village midwives, the important thing was to have a candidate who can brought the contraceptives to the health center, however, we have a problem in the pharmacy. *(IP. SW)"*

DISCUSSIONS

Most of the acceptors were housewives, therefore, the family income earned was obtained from the husband, but for the decisions in family planning, both of the husband and wife were involved so that there was a mutual agreement to choose the type of LTCM. Previous family planning experiences or from other families also have a role in contraceptive selection. The NHI facility can be used in serving the LTCM at the health center or assisted by the village midwife, SKD and PLKB could be carried out in simultaneous family planning services. A study done by Gonzalezet al., (2010) illustrated that low income lead to a health gap. Economic social inequality could cause the

LTCM services to be improperly implemented.

Women who worked have low desire to have more children than women who did not work. Women who work wanted to regulate their pregnancy so that they can work better and have children within a certain time according to the plan (Asihand Oesman, 2009).

Relatively inexpensive contraception would certainly encourage new acceptors to use it. However, this study found that information about side effects and fear in the use of LTCM was still believed by the public as a guide in making decisions in family planning. A study done by Nasution (2011) stated that there were some obstacles in the region in an effort to increase the use of LTCM, namely rumors that developed in East Java regarding the occurrence of IUD failure, prohibitions from husbands,and side effects that affect the relationships when having sexual activity. Therefore, it made people afraid in using LTCM.A study of Getinet (2014) stated thatLTCM was a contraceptive method that were safe, effective, inexpensive, reversible, required little or no maintenance, and has a good level of effectiveness than other methods such as hormonal.

The planning of contraceptive equipment/drug needs every year was done by calculating based on target data of family planning participation in Community Demand Fulfillment (CDF) both new FP participants and active FP participants by using certain formulations and contraceptive stock data in the warehouse at the end of the month (Pujihasvuty and Winarni, 2011). BKKBN Head Regulation (Perka) No. 151 / PER/EI/2011 which aimed at improving access, quality and ensuring post-natal family planning services in all service facilities including providing guarantees for the availability of tools, medicines, and contraceptive methods for all new FP participants; support for family planning services (IUD kit, implant kit, obgyn bed); enhancing provider competence in family planning services, and providing care for LTCM users (Nasution, 2011).

The availability of contraceptive in this study was fulfilled and was available in FP health facilities and reproductive health and service networks supported by the use of family planning services (BPPN, 2014). Constraints faced in the availability of contraceptives were networks to midwives that cannot be done because IPM/PPM has not been considered as a FP clinic so it must be a network of private practice doctors while private practice doctors rarely want to be networked. Thus, the chain of contraceptive availability for the provision of free family planning services was interrupted because it related to the procedure for making claims.

Based on the results of this study, it can be concluded that employment affected the use of LTCM. Income and the availability of contraceptive tools and medicines did not affect the use of LTCM.

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